HIV PMB application form

Request for additional cover from the Prescribed Minimum Benefits

MALCOR MEDICAL AID SCHEME
Administered by Discovery Health

Contact details
Tel: 0860 100 698 • PO Box 8012, Greenstone 1616 • www.malcormedicalaid.co.za

This form is valid for 2022, the latest version of the application form is available on www.malcormedicalaid.co.za

Who we are

The Malcor Medical Aid Scheme (referred to as 'the Scheme'), registration number 1547, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

Patient name and surname

Membership number

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Please complete this form if you wish to apply for additional cover for the diagnosis of, medicine for, or out-of-hospital management of a Prescribed Minimum Benefit (PMB) condition.
3. You (the member) must complete Section 1 of this form.
4. Your doctor must complete Section 2 and Section 3, and include detailed documents supporting your application.
5. Please email this completed and signed form with any support documentation to **HIV_Diseasemanagement@malcormedicalaid.co.za** or fax to 011 539 3151 or or post it to **Malcor Medical Aid Scheme, PO Box 536, Rivonia, 2128**.
6. A dedicated case manager will call you and your treating doctor let you know about our funding decision and the process to follow if your application is approved.
7. You can also contact our call centre on 0860 100 698 if you have any questions.
8. To avoid administration delays, please ensure this application is completed in full.

1. Principal Member's details

Title | Initials | Surname

ID Number

Membership number | Date of birth D D M M Y Y Y Y

Postal address

Code

Telephone (H) | (W)

Cellphone | Fax

E-mail

2. About the patient

Title | Initials | Surname

ID Number

Membership number | Date of birth D D M M Y Y Y Y

Postal address

Code

Telephone (H) | (W)

Cellphone | Fax

Email

May we communicate your information to you via e-mail ☐ or fax ☐

Relationship to main member

Patient's signature | Date of birth D D M M Y Y Y Y

(if patient is a minor, main member to sign)

3. Information about treatment request *(doctor to complete)*

3.1. Application for medical management

Out-of-hospital ☐

Condition	RPL consultation or procedure code	RPL description	Number of consultations or procedures per year

3.2. Application for medicine

Medicine requested *(please provide details)*

Condition	Medicine name, strength and dosage	NAPPI code	Frequency

3.3. Application for radiology

Condition	Code	Description	Quantity

3.4. Application for pathology

Condition	Code	Description	Quantity

4. . Doctor's details (doctor to complete)

Name and Surname

Practice number

Fax

Doctor's Signature

Date Y Y Y Y M M D D